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sions of the EQ-5D were assigned level 1 (no problems) as RLS was not considered to affect a patient's basic care and mobility. For dimension with more than one mapped level, a rounded average was considered. Other dimensions were assumed to be captured by the IRLS instrument. Significant inverse correlation was reported between the changes in utility scores and the changes in IRLS sum scores ($p < 0.001$). The regression model explains 56% of the variance in the changes in the utility scores: change_in_utility_scores = 0.0049 – 0.0277*change_in_IRLS_sum_scores. Similar results were found in the analyses for the changes from baseline to month 3. **CONCLUSIONS:** Changes in the EQ-5D derived utility scores can be reasonably estimated from the changes in the IRLS sum scores among patients with restless legs syndrome.

PND24

CAN THE CHQ-PF50 BE USED TO MONITOR CHANGES IN BEHAVIORAL AND EMOTIONAL FUNCTIONING IN CHILDREN TREATED FOR EPILEPSY?

de La Loge C[1], Yang H[2], Schiemann J[2], Hunter SJ[3]
[1]UCB Pharma SA, Braine l'Alleud, Belgium, [2]UCB Inc, Smyrna, GA, USA, [3]University of Chicago, Chicago, IL, USA

OBJECTIVES: To evaluate the appropriateness of the Child Health Questionnaire—Parent Form 50 (CHQ-PF50) in monitoring behavioral and emotional functioning in children with epilepsy treated with antiepileptic drugs (AEDs), by comparing and correlating it with the Child Behavior Checklist (CBCL). **METHODS:** Clinical data from a double-blind placebo (PBO) controlled study of adjunctive therapy of levetiracetam (20–60 mg/kg/day) in children (4–16y) with partial onset seizures (POS), which included the CBCL and the CHQ-PF50 to assess behavioral and emotional functioning, were used. Pearson correlation coefficients between scores of the two instruments measuring similar concepts were calculated, and the two instruments were compared for item content, acceptability, reliability, validity and responsiveness to various factors. **RESULTS:** 78 patients had CHQ-PF50 and CBCL data at baseline and evaluation (12 weeks). Both questionnaires showed good acceptability in terms of return rates (81.6% at the lowest) and missing data (average/patient < 1%). All subscales except CHQ-PF50 General Health showed good reliability in terms of Crohnbach's α ($r > 0.700$). All scores of the CHQ-PF50 measuring behavioral or emotional functioning (Behavior, Mental Health, Role/Social Limitations-Emotional/Behavioral and the Psychosocial Summary Score) showed large correlations with CBCL scores measuring similar concepts ($-0.821 < -0.433$) at baseline but smaller correlations for change from baseline ($-0.470 < -0.030$). CHQ-PF50 behavior-related scores seemed more responsive to the occurrence of behavioral adverse events than corresponding CBCL scores, although both showed limited sensitivity (small Standardized Response Means). The CBCL Externalizing score, however, appeared to be more sensitive when comparing treatment groups than the corresponding CHQ-PF50 Behavior score ($p = 0.011$ vs. $p = 0.871$ from ANCOVA). **CONCLUSIONS:** The CHQ-PF50 scores assessing behavioral and emotional functioning have shown good reliability, validity, and high consistency with the corresponding CBCL scores. However, the behavior score of the CHQ-PF50 appeared to be less sensitive in showing between-treatment group differences than the more specific and comprehensive Externalizing score of the CBCL.

PND25

EVALUATION OF A BRIEF DEMENTIA SCREENING TEST FOR PARKINSON'S DISEASE (PD-BDST) IN A CLINICAL PRACTICE SETTING

Andrés I[1], Kulisevsky J[2], Balañá M[1], Pagonabarraga J[2], Llebaria G[2], Gobartt AL[3], Arranz J[4]
[1]NOVARTIS FARMACEUTICA S.A, Barcelona, Spain, [2]Hospital de Sant Pau, Barcelona, Spain, [3]Novartis Pharmaceuticals, Barcelona, Spain, [4]LABORATORIOS ESTEVE, Barcelona, Spain

OBJECTIVES: To evaluate patient and physician satisfaction with the use of a Brief Dementia Screening test for Parkinson's disease (PD-BDST) in a clinical practice setting. **METHODS:** An observational, cross-sectional and multicenter study was conducted, including 471 PD patients. The PD-BDST and Mini-Mental State Examination (MMSE) were administered to patients. A patient satisfaction questionnaire rated with a visual scale from 0 to 10 was used to assess patient satisfaction. Physician satisfaction ($n = 52$) was measured using a satisfaction questionnaire rated with a Likert scale from 0 to 5. **RESULTS:** The mean PD-BDST score ($\pm$SD) was 18.5 ± 6.3, and 36.3% of patients presented scores compatible with dementia (PD-BDST score $\leq$15 points). There was a high correlation between the score of the Mini-Mental test (29.05 ± 5.4) and the PD-BDST scores ($r = 0.73$, $p < 0.001$). Mean satisfaction scores for patients and physician were 27.6 ± 7.4 and 3.60 ± 0.58, respectively. A total of 37.7% of patients reported not having any trouble completing the test, and 22.6% expressed difficulties in only one part of the test. The proportion of satisfied patients was 77.3%. Patients with the least risk of poor satisfaction were those with a PD-BDST higher score (OR = 0.9) and those reporting less difficulties completing the test (OR = 0.8). More than half of physicians presented a score higher than 3.73. The mean scores for PD-BDST applicability, handling and reliability of physicians were 3.5 ± 0.7, 3.7 ± 0.6 y 3.1 ± 0.5. **CONCLUSIONS:** Previous studies have shown the PD-BDST to be a specific test to diagnose PD-related dementia able to distinguish between healthy controls, non-demented PD and demented PD. In the present study, PD patients found the PD-BDST satisfactory. Participating investigators considered the test to be valid, quick and simple to administer in a clinical practice setting.

PND26

ARE THERE DIFFERENCES IN PATIENT SATISFACTION WITH INSOMNIA MEDICATIONS? PILOT RESULTS FROM A NOVEL REGISTRY

Bharmal M[1], Cascade EF[2], Gemmen EK[1]
[1]Quintiles, Falls Church, VA, USA, [2]iGuard Inc, Falls Church, VA, USA

OBJECTIVES: Insomnia is prevalent in many populations, both as a primary disorder and as a symptom secondary to a medication or underlying condition. The objective of this study was to assess patient satisfaction with a variety of insomnia medications used in a community-based population in the U.S. **METHODS:** Patients are recruited from multiple sources including physician, pharmacy and online referrals and asked to report ongoing medications on the project website (www.iGuard.org). A random sample of patients are contacted to complete the Treatment Satisfaction Questionnaire for Medication Version 1.4 (TSQM), a 14-item reliable and valid instrument to assess patients' satisfaction with medication, providing scores on four scales—effectiveness, side effects, convenience and global satisfaction. TSQM scores range from 0 to 100, with higher scores indicating higher satisfaction on the domain. Analyses were conducted to explore differences in patient satisfaction across insomnia medications. **RESULTS:** A total of